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8
9 **BEFORE THE**
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. **2010-469**

12 **QIXIA LIANG**
7647 Pipit Place
13 San Diego, CA 92129

ACCUSATION

14 **Registered Nurse License No. 494192**

15 Respondent.

16
17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
20 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department
21 of Consumer Affairs.

22 2. On or about August 31, 1993, the Board of Registered Nursing issued Registered
23 Nurse License Number 494192 to Qixia Liang (Respondent). The registered nurse license will
24 expire on February 28, 2011, unless renewed.

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1 8. California Code of Regulations, title 16, section 1443, states:

2 "As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the
3 failure to exercise that degree of learning, skill, care and experience ordinarily possessed and
4 exercised by a competent registered nurse as described in Section 1443.5."

5 9. California Code of Regulations, title 16, section 1443.5, states:

6 A registered nurse shall be considered to be competent when he/she
7 consistently demonstrates the ability to transfer scientific knowledge from social,
8 biological and physical sciences in applying the nursing process, as follows:

9 (1) Formulates a nursing diagnosis through observation of the client's
10 physical condition and behavior, and through interpretation of information obtained
11 from the client and others, including the health team.

12 (2) Formulates a care plan, in collaboration with the client, which ensures
13 that direct and indirect nursing care services provide for the client's safety, comfort,
14 hygiene, and protection, and for disease prevention and restorative measures.

15 (3) Performs skills essential to the kind of nursing action to be taken;
16 explains the health treatment to the client and family and teaches the client and
17 family how to care for the client's health needs.

18 (4) Delegates tasks to subordinates based on the legal scopes of practice of
19 the subordinates and on the preparation and capability needed in the tasks to be
20 delegated, and effectively supervises nursing care being given by subordinates.

21 (5) Evaluates the effectiveness of the care plan through observation of the
22 client's physical condition and behavior, signs and symptoms of illness, and
23 reactions to treatment and through communication with the client and health team
24 members, and modifies the plan as needed.

25 (6) Acts as the client's advocate, as circumstances require, by initiating
26 action to improve health care or to change decisions or activities which are against
27 the interests or wishes of the client, and by giving the client the opportunity to make
28 informed decisions about health care before it is provided.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
administrative law judge to direct a licensee found to have committed a violation or violations of
the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
enforcement of the case.

FACTS

11. On September 2, 2007, Robert N., a 29-year old male, was attacked by a group of
people. During the attack, Mr. N. was hit with a beer bottle in the right eye and was punched

1 throughout his body. He fell down three steps and landed on his left side. As a result of his
2 injuries, Mr. N. was taken by ambulance to Sharp Memorial Hospital in San Diego, California.

3 12. Mr. N. arrived in the emergency room at 2354 on September 2, 2007. Both of his
4 eyelids were swollen, although more swollen on the right. Mr. N. reported that his vision was
5 normal at that time. A CT scan was performed and revealed an orbital floor fracture on the right
6 side and a nasal fracture.

7 13. R.N. was admitted to the hospital and arrived at the nursing unit at 0428 hours on
8 September 3, 2007 where he was assessed by Nurse H. Mr. N. complained of right eye and nasal
9 pain. The nursing documentation noted that Mr. N.'s right eye was swollen and ecchymotic
10 (bruised). Ice packs were applied to the right side of Mr. N.'s face. There was no indication in
11 the notes that R.N. had any vision problems at this time.

12 14. Mr. N. underwent surgery at 1559 hours on September 3, 2007 for reconstructive
13 surgery including the placement of an orbital implant. Dr. B. performed the surgery and was
14 assisted by Dr. V. Surgery was noted to have been uneventful.

15 15. After surgery at 1713 hours, Mr. N. was sent to the post-anesthesia care unit (PACU)
16 where Respondent took over his care. Upon his arrival in PACU, Respondent performed an
17 initial assessment and noted in the patient chart that Mr. N. had slight swelling in the right eye
18 area and that it was ecchymotic and that the surgeon was "aware." Ice packs were applied on Mr.
19 N.'s face and the head of the bed was elevated 35°. Respondent also noted that Mr. N.'s vital
20 signs were stable and that he denied needing any pain medication. Respondent recorded Mr. N.'s
21 pain assessment was "0" at 1740 hours, "N" (that is, behavioral and physiological cues indicate
22 no pain) at 1755 hours, "0" at 1800 hours and "N" at 1810 hours. According to Mr. N., he told
23 Respondent that he could not see out of his right eye and had pain. Respondent did not perform a
24 neurological assessment of Mr. N.'s eye, either visually or by using the light test to check his
25 reaction, during the hour and 7 minutes he was at PACU.

26 16. Mr. N. was transferred back to the nursing floor at 1825 hours and Nurse G. resumed
27 his care. When he arrived at the floor, Nurse G. noted that R.N. was complaining of a lot of pain,
28 ranked a level "8" by R.N. and increasing to a level "10" by 1900 hours. R.N. was subsequently

1 given Morphine 4 mg and his pain level decreased. Mr. N. advised Nurse G. that he could not see
2 out of his right eye but his complaints of loss of vision were not recorded in the nursing notes.
3 Pain medication was administered at 2100 hours and the scheduled Toradol was given at
4 midnight and at 0600 hours.

5 17. At 2000 hours on September 3, 2007, Nurse R.G. took over Mr. N.'s care for the
6 night shift. Mr. N. advised Nurse R.G. that he had no vision in his right eye. The nursing notes
7 did not contain any references to complaints of lost vision in Mr. N.'s right eye by Nurse R.G.

8 18. At 0800 hours on September 4, 2007, the day after surgery, Nurse P. took over Mr.
9 N.'s care. Nurse P. performed an assessment of Mr. N., including a neurological check. Nurse
10 P. noted that Mr. N.'s right eye was swollen, ecchymotic and could only open slightly. Nurse P.
11 also noted that Mr. N. reported not being able to see with the right eye. Nurse P. asked Mr. N.
12 whether this was something new. Mr. N. advised Nurse P. that he had not been able to see with
13 his right eye since surgery and that he reported it to the nurses. Nurse P. did not review the
14 patient's chart to see if loss of vision had been charted before. Respondent did not contact the
15 doctor or advise the charge nurse of Mr. N.'s reported loss of right eye vision. Nurse P. assessed
16 Mr. N. again at 1000 hours but did not perform another neurologic check while she was on duty
17 that day.

18 19. At approximately 1430 hours on September 4, 2007, Nurse Practitioner H. visited Mr.
19 N. because he was supposed to be discharged that day. Mr. N. told Nurse Practitioner H. that he
20 could not see out of his right eye. Nurse Practitioner H. conducted a visual examination and
21 neurological assessment of Mr. N. and determined that he had right eye blindness. Nurse
22 Practitioner H. tried to reach the doctor who performed the surgery. When she learned he was out
23 of town at a conference, she contacted the trauma surgeon, who subsequently examined Mr. N.
24 The trauma surgeon then telephoned Dr. Z. (the ophthalmologist) to advise of Mr. N.'s condition
25 and Nurse Practitioner H. telephoned Dr. V. because he had assisted in the first surgery. Dr. V.
26 recommended that Mr. N. see Dr. Z. and also ordered a right orbit CT scan to rule out a
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1 retrobulbar hematoma.¹ At 1435 hours, Dr. Z. called Respondent on the floor and requested that
2 Mr. N. be taken to the ER eye center for evaluation at 1700-1730 hours. Because of a mix-up
3 with the CT scan order, the CT scan was not performed until after Dr. Z. examined Mr. N.

4 20. When Mr. N. was examined by Dr. Z. approximately 24 hours after surgery, his right
5 eye was bulging and intraocular pressures were high. A canthotomy² was performed to relieve
6 pressure. A CT scan of the right eye was performed at 1827 hours at which time a new
7 hematoma was discovered in the right orbit. The hematoma was detected approximately 25 hours
8 after the first surgery. As a result, Mr. N. was taken back to surgery that evening to remove the
9 orbital implant from the first surgery.

10 21. Mr. N. never recovered sight in his right eye due to the compression of the optic
11 nerve caused by the hematoma. According to Dr. Z., if the hemorrhage had been caught within
12 two hours of onset, Mr. N.'s vision could have been saved.

13 22. R.N. never recovered sight in his right eye due to the compression of the optic nerve
14 caused by the hematoma. According to the ophthalmologist, if the hemorrhage had been caught
15 within two hours of onset, R.N.'s vision could have been saved.

16 FIRST CAUSE FOR DISCIPLINE

17 (Gross Negligence)

18 23. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross
19 negligence as defined in title 16, California Code of Regulations, section 1442, in that during her
20 post-operative care of Mr. N., Respondent failed to perform an assessment of Mr. N.'s right eye
21 every 15 minutes, either visually or by using the light test to check his reaction, during the hour
22 and 7 minutes Mr. N. was at PACU, which Respondent knew or should have known, could have,

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24 ¹ "Retrobulbar hematoma is bleeding in the potential space surrounding the globe. It
25 results from blunt trauma as well as from retrobulbar injection and operative intervention. This
26 entity can compromise vision, so immediate recognition and intervention are warranted. Bleeding
27 typically results from injury to the infraorbital artery or one of its branches. Accumulation of
28 blood results in an increase in pressure, ultimately compressing blood vessels and other
structures." James G. Adams, *Emergency Medicine*, at <http://www.expertconsultbook.com>
(accessed March 23, 2010)

² A canthotomy is an incision of the canthus, which is either corner of the eye where the
upper and lower eyelids meet.

1 and in fact did, jeopardize Mr. N.'s health or life as more fully set forth in paragraphs 11-21
2 above, and incorporated by this reference as though set forth in full herein.

3 **SECOND CAUSE FOR DISCIPLINE**

4 **(Incompetence)**

5 24. Respondent is subject to disciplinary action under Code section 2761(a)(1) for
6 incompetence as defined in title 16, California Code of Regulations, sections 1443 and 1443.5, in
7 that Respondent did not possess the degree of learning, skill, care and experience to perform a
8 neurological assessment of R.N., such as a visual examination or light test, while he was at
9 PACU.

10 **PRAYER**

11 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
12 and that following the hearing, the Board of Registered Nursing issue a decision:


13 1. Revoking or suspending Registered Nurse License Number 494192, issued to Qixia
14 Liang;

15 2. Ordering Qixia Liang to pay the Board of Registered Nursing the reasonable costs of
16 the investigation and enforcement of this case, pursuant to Business and Professions Code section
17 125.3;

18 3. Taking such other and further action as deemed necessary and proper.

19
20
21 DATED: _____

3/29/10


LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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